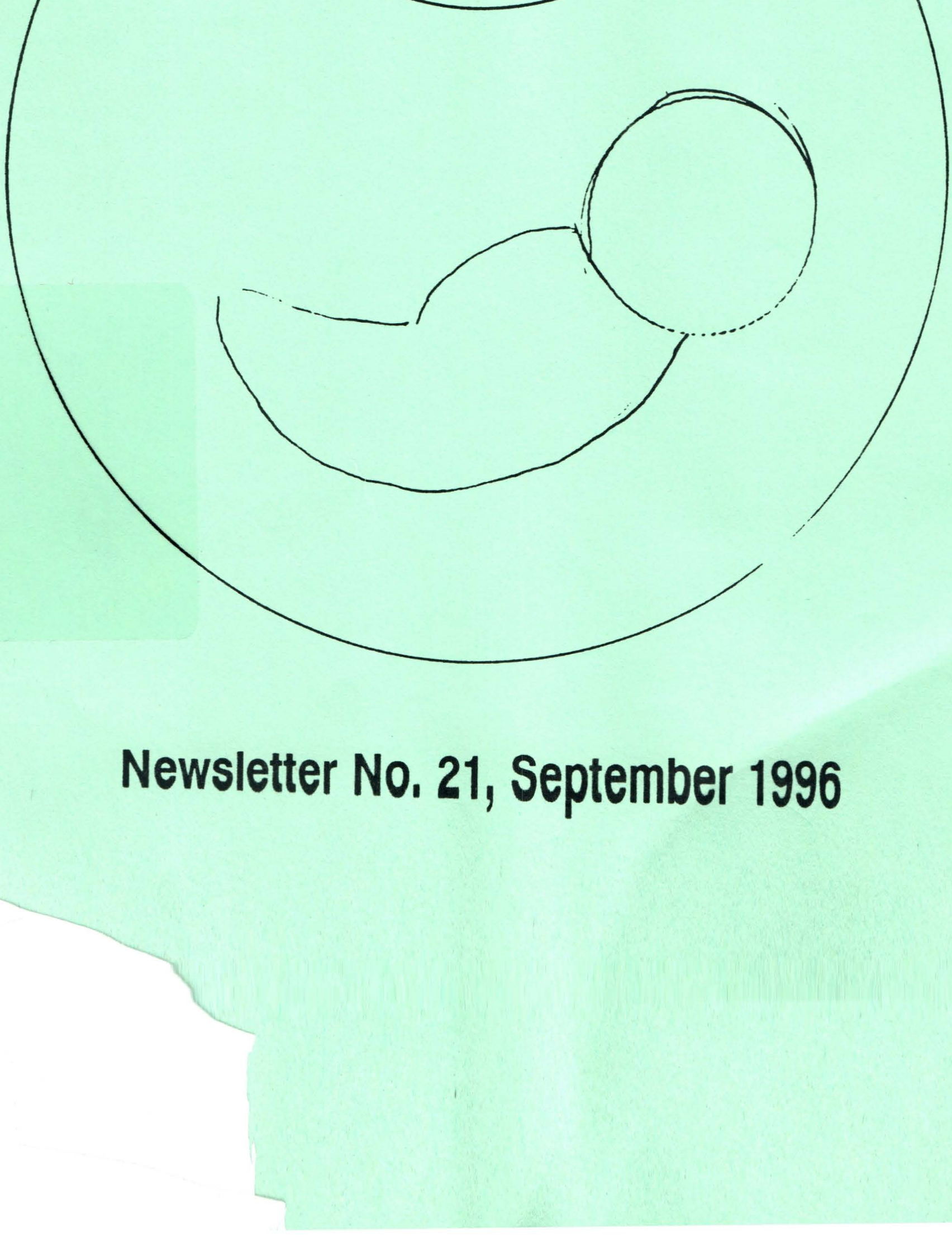
THE ALLIANCE OF MIDWIVES, MATERNITY AND NEONATAL NURSES OF NEWFOUNDLAND AND LABRADOR



Newsletter No. 21, September 1996

The Alliance of Midwives, Maternity and Neonatal Nurses of Newfoundland and Labrador

(A Special Interest Group of the ARNN)

Newsletter No. 21 (new issue) - September, 1996

International Year for the Eradication of Poverty

I hope that you have all had a good summer. Now it is back to reality and the restructuring of the health care system. You will find in this Newsletter an item about the provincial government's Social Policy Advisory Committee. The SPAC members are holding meetings around the province to obtain comments about different subjects, including health care, which you may wish to attend.

Another item involving restructuring is the future of the Alliance. The Alliance was formed in 1983 when the Atlantic Region Midwives Association (formed in 1974) and the Atlantic Region Maternity and Neonatal Nurses Association mainly consisted of Newfoundland midwives and nurses. (For more details see the 1994 Alliance Newsletters). The question now is - should the Alliance revert back to separate Associations? The Midwives Association has kept its identity over the years, as is needed in order to be part of the Canadian Confederation of Midwives, but has combined with the Alliance for many activities. The Alliance needs a new executive (president, secretary, treasurer) and has been existing without a president for the past year. Members will be kept informed but if you have any comments please submit them to a member of the Alliance executive (listed below).

In the last Newsletter there was a copy of the CPS Statement on "Facilitating Discharge Home Following a Normal Term Birth". Cheryl Levitt, Chairperson of the Dept. of Family Medicine at McMaster University is looking for feedback. If you have any comments, concerns, etc. please fax her at 905-528-5337 or E-mail clevitt@fhs.mcmaster.ca

This Newsletter includes the annual list of recent MUN library acquisitions. The Midwives Chronicle (Royal College of Midwives) issues are being brought up to-date. Primary Health Care (Royal College of Nurses) is being added.

Thank you to those who submitted items for this Newsletter. The editor needs appropriate materials but the submitter accepts copyright responsibility for the item to be reproduced. Details of the cost of the Newsletter for the last 4 years is given below.

Past members who have not paid for 1996 are not on the current mailing list. A membership form is at the back of this Newsletter.

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**Next Alliance Meeting: Thursday, September 26, 1996, 8 p.m.
at Roma Quinton's, 17 Creston Place, St. John's**

**Next Friends of Midwifery Meeting is in October
For Information contact: Joan MacIntosh, 14 Taylor Place,
St. John's, NF A1A 1L5 (Telephone: 722-5930)**

Executive Members

President:
Treasurer: Clare Bessell
Librarian: Bernardine Moyles
Secretary: Roma Quinton
Publicity: Janet Murphy-Goodridge
Newsletter: Pearl Herbert

Meetings

There have been no meetings during the summer months.

Alliance Membership and Newsletter Distributions from Pearl Herbert

Since 1992 an annual record has been kept of the names of the Alliance members, and of the costs of the Newsletters. The following table shows the details of the members, how many were midwives, and if they lived in the St. John's/Mt. Pearl area.

Membership

Year	Basic Fee p.a.	Total Members	Midwives	St.John's
1992	$10	29	8 (27.5%)	23 (79%)
1993	$10	40	24 (60.0%)	22 (55%)
1994	$15	45	25 (55.0%)	28 (62%)
1995	$15	39	22 (56.5%)	19 (49%)

The next table also shows the basic annual membership fee (midwives and members outside of the country pay an additional amount, unemployed and retired members pay less). The number of Newsletters printed include those for Alliance members plus a copy for the ARNN library and one for the Health Sciences Library (where it is held on reserve). Non-members who contribute to a Newsletter are sent a copy, plus extra copies are used for advertising the Alliance and recruiting new members. At the beginning of a financial year more copies are printed as past members who have not renewed their membership are given a further reminder that their fee is due.

The Newsletter information shows the average annual number of pages per Newsletter, the average annual cost of each individual copy with the total cost to each member of their 4 Newsletters a year. In 1994 there was an extra issue of the Newsletter. The June issue contained the proceedings of the National Midwifery conference, held in St. John's, for which the printing costs were paid by the Canadian Confederation of Midwives (CCM) and so is not included here. There was a regular issue of the Newsletter in July 1994. In calculating these costs no attempt has been made to adjust for those who pay either $10 or $30. The $5 extra paid by the midwives is not retained by the Alliance but is forwarded to the CCM to pay for the Midwives Association's membership in that organization.

Newsletters

Year	Basic Fee p.a.	# Pages	Cost/Copy	Member p.a
1992	$10	8	$0.58	$2.34
1993	$10	12	$0.66	$2.66
1994	$15	37	$1.28	$5.13 +
1995	$15	41	$1.48	$5.93

The figures for 1996 are incomplete but so far membership and Newsletter costs are very similar to 1995.

Over the last 2 or 3 years postage rates have been increasing e.g. in 1995 it cost $1.40 to mail a single copy of the Newsletter and in 1996 it costs $1.45 for a similar Newsletter. An effort is made to send Newsletters by internal mail whenever possible. Another reason why mailing costs have increased is that more members are from outside the St. John's area, plus also more members are in part-time\casual employment and need to have their Newsletter mailed to their home so that it does not get lost when they are not present at the work-place.

As interest has increased in the Alliance so have the number of articles contributed to the Newsletter; resulting in more pages for each issue. However, changes were made in the printing arrangements and the cost decreased by ½ cent per page from the Fall of 1993. Members requested a cover and in July 1994 a cover page was added (showing the original logo from 10 years previous).

As can be seen from the title of the Alliance, members are from three main interest groups, all with the common goal of promoting safe, good care for mothers and babies. An endeavour is made to reflect these interests in the issues of the Newsletter, although it does depend on the materials submitted to the Editor. Information of interest to members is welcomed and may be submitted to the Editor by either members or others (including students). It does help if the information is on disk (stating whether it is wordperfect 5.1 or 6 or windows95) as it saves the Editor having to retype the article; but this should not prevent someone from making a contribution of a typed or handwritten paper. The person submitting the information is responsible for obtaining copyright permission when necessary. A little editing may be made but the submitter is ultimately responsible for the accuracy of the information. Letters are welcomed.

Society of Obstetricians and Gynaecologists of Canada ($60)
Midwives and Nurses can apply to be associate members of the SOGC. Midwives are seeking to have a representative on the SOGC Council where there have to be 50 members being represented. Nurses are already represented. One can only register as either a midwife or a nurse, not as both. A new membership paid now will last until January 1998. For more information contact Anne-Marie Copeland, SOGC Membership Services Coordinator, at 1-800-561-2416. Also inquire about the SOGC 1995 publication "Healthy Beginnings".

Extended Roles - Midwives and Nurse Practitioners from Pearl Herbert

Extended roles are being discussed in various areas of the health care system. For nurses this can include clinical nurse specialists, nurse practitioners, and any areas where nurses are practising beyond their expected role. Probably not their traditional role as prior to professional associations being formed nurses used to practise and give care in what is currently considered to be outside of the practise of nursing. Now, for a number of legal and ethical reasons, nurses have specific guidelines as to what is nursing. When there is an overlap there are transferred/shared skills with the medical profession. Midwives in Canada, as a profession in their own right, are including in their legislation areas which in the recent past have belonged to others, especially the medical profession, and to be paid by the province (by salary or by the provincial health insurance). Midwifery legislation includes hospital admitting and discharge privileges, prescribing non-narcotic drugs, requisitioning routine laboratory and radiology tests, and ambulance services. Nurse practitioners who have received special preparation also have the knowledge to use these services, but special legislation is required. Nurses are able to practise in an extended role in northern Newfoundland and Labrador as a result of a special agreement between the ARNN, NMA, and NMB. If nurses could be prepared and legally allowed to work in an extended role elsewhere in the province would this relieve the shortage of physicians?

In many areas of Britain one finds nurses, midwives, physicians, social workers practising from one building, referring to each other, and having team meetings. If such a system was possible in this province would it alleviate some of the stress which physicians feel when having to work alone in an isolated community? If legislation permitted nurse practitioners, midwives, as well as the community health nurses, to all work together, physicians would be able to have free time which may then encourage those who like rural practice to stay in the more remote areas of the province.

At a recent meeting held to discuss "A Strategic Social Plan for Newfoundland and Labrador" one of the issues raised was the lack of insurance coverage to those who were not physicians. When a physician wants to involve another professional in a person's care they have to ensure that the person can afford to pay privately. If the person is not in a financial position to do this the physician has no other alternative but to refer to another physician, who will cost MCP more money and may not be the best choice for that person. (An example given was having to refer to a psychiatrist when really a psychologist would better be able to provide what was needed for that individual). Health promotion can help to improve life styles and prevent costly high-technology surgery in the future, but teaching, promoting and counselling are not covered by the provincial health insurance. Few people in this province have any choice in their health care. On the Avalon Peninsula all women having a baby have to go to the Grace General

Hospital. There are fewer family physicians providing obstetrical care and so the women are referred to an obstetrician. Even if they have chosen to attend a specific obstetrician, when they go into labour in the night, or at weekends, they have to see the obstetrician and resident who are on call. ("Their" obstetrician is not present unless on call).

Similar issues were discussed at the National Health Forum meetings and the Advisory Health meeting. Legislation would be needed to change the provincial insurance regulations. (From having attended these meetings one is struck by how many issues require policy and legislation changes. Examples include: no day care permitted for the under 2 year olds; the lack of incentives to encourage women on welfare to breast feed as only women who bottle feed are given extra money by Social Services.)

There is a two tiered health care system in this province where those who have the money can be clients/consumers, and those without the money have to be patients who cannot make choices. This results in a high cost to the health care budget as money is being spent unnecessarily to provide consultant care when it is not needed.

At a recent ARNN meeting, at which over 70 nurses from around the province (on site and by teleconference) attended, the Nurse Practitioner issue was discussed and a steering committee is being formed.

The provincial government's Social Policy Advisory Committee is going to be visiting various areas of the province during the next few weeks. They will be holding meetings to discuss health care, education, justice, municipal services, housing and social services. When they are in your area ensure that they are told what you consider needs to be changed and your suggestions for improvement. Briefs and letters can also be submitted to:

The Social Policy Advisory Committee,
P.O. Box 8700, St. John's, NF A1B 4J7
(Telephone: 709-729-2646; or 1-800-814-5611)

Telephone and find out when the Committee is planning to be in your area. Also request a copy of: Government of Newfoundland and Labrador. (1996, June). Strategic Social Plan Consultation Paper. This is available from the above address, and from the 3rd floor of the Beothuck Building, 20 Crosbie Road, St. John's.

Aboriginal Nurses Association ($50 regular, $40 associate)
Nurses who do not have Aboriginal Ancestry are able to become associate members of the ANA of Canada (special interest group of the CNA). For information write to: Aboriginal Nurses Association of Canada, 1785 Alta Vista Drive, Suite 103, Ottawa, ON K1G 3Y6

Canadian Perinatal Surveillance System Steering Committee at which Pearl Herbert represents midwives.

A meeting was held September 16-17, 1996. Over 1200 reports of the progress of this committee have been sent to all provincial/ territorial ministers of health and other interested persons. Only two provinces have not acknowledged receipt of these and answered the questions. Budget cut-backs have resulted in some staff changes in LCDC as contractual staff have to be replaced by those who were laid off. The indicator list was discussed. At present there are too many indicators which would result in too many tables. The province of Manitoba has ceased to use the terms "low risk" and "high risk" and others queried what "appropriate care" and "appropriate place of birth" really mean. In Ontario part of the province is no longer carrying out routine diabetes screening. This is a "natural experiment" and will be studied for the health effects for the women and babies plus the financial effects. Definitions change from province/territory to province/territory.

Confidentiality is another big concern. The Canadian Institute of Hospital Information (CIHI) is interested in the CPSS but it is not known how the information would be shared. CIHI wants to expand out of the acute care setting into the community. Also provincial governments may need further consents for information to be shared between CIHI and CPSS. In 1995 there was a 78% collaboration/use between provinces/territories and CIHI. (Some provinces/territories have 100% utilization and others only 39%).

At present provinces/territories are collecting data. The type of data and maternal/neonatal definitions may vary. An endeavour will be made to find out the variables on the hospital discharge abstract forms, and to see whether they are the same or different from those given to CIHI. In many provinces hospitals have to provide the information to a provincial government department in order to collect financial payments. CIHI consider that they provide faster analysis and feedback to what was previously available, and also they provide information sessions for those who use their services.

There was a discussion about women having their own prenatal records. Some members of the CPSS do not consider that this is a good idea because they could get lost; although the care provider would also have a copy. There was talk about "smart cards" which are deciphered when placed in a machine, but it was pointed out that the women should know what is on their records which can also be used as teaching tools. Results from surveys show that the majority of women do look after their records as they consider them to be important information.

A set of slides is being created which members can borrow. At present they are being made on disk on "power point". A dictionary of indicators is being written and this will be for professionals. The response committee is working on how information regarding "red flag" indicators can be conveyed back to the area. How the location responds will depend on whether or not they know the reason for a "problem", or whether they want help in finding out why this is occurring.

A comparison of two groups collecting information on congenital anomalies was reported. Questions were raised about the validity of a diagnosis. Often a temporary diagnosis is given in the first days after birth but then after a more thorough follow-up the diagnosis may be confirmed or changed. Does the child then get entered twice into the CIHI, especially if the physicians are located at different hospitals? CIHI could record every mention of an abnormality even when it is not confirmed. There are 22 accredited genetic centres in Canada but other places also report and, unlike Newfoundland, all diagnosis are not sent to a central place. Antenatal diagnosis may occur in one hospital but the baby may be born in another one, and in the meantime the mother may have changed her name, resulting in two reports for one baby.

Other countries have been visited in order to review how surveillance systems operate. In most places registries were instituted as inventories of births and have been changing to become surveillance systems. One item that they all find that they need is to calculate their financial costs. Ontario has an ongoing Case Costing Project. When using the CIHI only physician charges are recorded (midwives have hospital privileges in Ontario). For a vaginal birth obstetricians are paid $318, which is similar to Newfoundland. Even for normal births and early discharge home there is still an overhead for hospital service because the availability of beds has to be maintained (housekeeping, utilities, maintenance etc).

A list of provincial surveys is being compiled. Registration of fetal/infant mortalities are being studied. When linking births with deaths it is discovered that not all birth registrations are readily found. Most provinces/territories have a list of all residents for medical insurance purposes and names are deleted when the person dies, but the cause of death is not usually shown. Other studies have found that using death certificates to collect data for women who died from pregnancy related causes may not provide the same number of deaths as can be found when studying hospital records.

There was a discussion on how to find a woman's socio-economic status (SES). Postal codes were suggested but not everyone uses the code for where they live; off reserve Indian women often use a reserve address, people may use a general post office box number. Quebec is the only province which records the woman's SES on the registration certificates. There was also a discussion about how to collect data for Inuit and Innu women and babies, who are not included in the First Nations data.

A rotation of committee members will commence in 1997, just as the groundwork is being completed and prior to the initiation of the collection of indicator information. This first rotation will be staggered; some serving 2 years and others 3 or 4 years. Associations will be asked if they wish to elect a new member or to re-elect the same representative (who may serve two terms of 3 years). In this instance, a re-election would provide members an opportunity to see some of the results of their work.

Update of the Memorial University Library Resources for 1995/1996

List of Resources of particular interest to Alliance members. Additions to those printed in the 1994 Newsletters, and the September 1995 Newsletter. Once again this year we have to thank Linda Barnett of the Health Sciences Library for retrieving the information for us, but the system has changed to UNICORN and so the format is slightly different.

Childbearing

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New York : M. Dekker, c1995.
CALL NUMBER: QP 772 F6 F623 1995, LOCATION: QEII

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Sexual behaviour, human reproduction, contraception.
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London : Arnold, 1995.
CALL NUMBER: WQ 100 O14 1995, LOCATION: HEALTH SCIENCES

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Edinburgh : Churchill Livingstone, 1995.
CALL NUMBER: WQ 100 T942 1995, LOCATION: HEALTH SCIENCES

Chestnut, David H. (1994). Obstetric anesthesia : principles and practice ; with 272 illustrations
St. Louis : Mosby, c1994.
CALL NUMBER: WO 450 O141 1994, LOCATION: HEALTH SCIENCES

Cohen, Susan M., Kenner, Ann, and Hollingsworth, Andrea O. (1991). Maternal, neonatal, and women's health nursing
Springhouse, Pa : Springhouse Corp., c1991.
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Colker, Ruth. (1994). Pregnant men : practice, theory, and the law
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Teenage parents, mothers and fathers, in the United States.
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CALL NUMBER: HQ 759 .64 C68 1995, LOCATION: QEII

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Publication info: Oxford [England] ; New York : Oxford University Press
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Motherhood, mothers, daughters and childbirth in the United States.
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A Colour atlas of Doppler ultrasonography in obstetrics : an introduction to its use in maternal fetal medicine
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New York : W. Morrow and Co., c1994.
CALL NUMBER: WQ 200 M473 1994, LOCATION: HEALTH SCIENCES

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Smetana, Judith G. (editor). Beliefs about parenting : origins and developmental implications
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Mothers in literature.
Ithaca, N.Y. : Cornell University Press, 1994.
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Sweet, Betty R. (1988). Mayes' midwifery : a textbook for midwives / Mayes, Mary (11th edition).
London : Bailli*ere Tindall, 1988.
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CALL NUMBER: RG 518 G7 W54 1995, LOCATION: QEII

Wood, C., Hill, D. J., Maher, P. J. (editors). (1994). Gynaecological operative laparoscopy : current status and future development
London : Balliere Tindall, 1994.
CALL NUMBER: WP 141 G997 1994, LOCATION: HEALTH SCIENCES

Neonatal

Aboriginal Nurses Association of Canada. (1996). Healthy children healthy nations : a framework document to support the well-being of First Nations' children.
Ottawa, ON : Published by the Aboriginal Nurses Association of Canada, 1996. Funding provided by the Child Development Initiative, Medical Services Branch, Health Canada.
CALL NUMBER: WA 310 H435 1996, LOCATION: HEALTH SCIENCES

Alpert, Bruce et al. (1995). Neonatal intensive care
Redmond, WA : SpaceLabs Medical, 1995.
CALL NUMBER: WS 421 N438 1995, LOCATION: HEALTH SCIENCES

Cohen, Susan M., Kenner, Ann, and Hollingsworth, Andrea O. (1991).
Maternal, neonatal, and women's health nursing
Springhouse, Pa : Springhouse Corp., c1991.
CALL NUMBER: WY 157 C678M 1991, LOCATION: HEALTH SCIENCES

Gorrie, Trula Myers, McKinney, Emily Slone, and Murray, Sharon Smith. (1994). Foundations of maternal newborn nursing.
Philadelphia, PA : W.B. Saunders, 1994.
CALL NUMBER: WY 157.3 G673F 1994, LOCATION: HEALTH SCIENCES

Hale, Thomas W. (1996). Medications and mothers' milk (5th edition).
Amarillo, TX : Pharmasoft Medical Publishing, 1996.
CALL NUMBER: WS 39 H164M 1996, LOCATION: HEALTH SCIENCES

Hatch, David J., Sumner, Edward, and Hellmann, Johathan. (1995).
The surgical neonate : anaesthesia and intensive care
London : E. Arnold, 1995.
CALL NUMBER: WO 440 H361N 1995, LOCATION: HEALTH SCIENCES

Johnson, Robert V. (editor-in-chief). (1994) Mayo Clinic complete book of pregnancy & baby's first year
New York : W. Morrow and Co., c1994.
CALL NUMBER: WQ 200 M473 1994, LOCATION: HEALTH SCIENCES

Olds, Sally B., London, Marcia L., and Ladewig, Patricia Wieland. (1996). Maternal-newborn nursing : a family centered approach (5th edition).
Menlo Park, CA : Addison-Wesley Pub. Co., 1996.
CALL NUMBER: WY 157.3 O124 1996, LOCATION: HEALTH SCIENCES

Phillips, Celeste R., 1933- (1996). Family-centered maternity and newborn care : a basic text. (4th edition).
St. Louis, MO : Mosby, c1996.
CALL NUMBER: WY 157.3 P558F 1996, LOCATION: HEALTH SCIENCES

Feeding

Canadian Institute of Child Health. (1993) Breastfeeding guidelines for health care providers (1st edition).
(1996) National breastfeeding guidelines for health care providers (2nd edition).
Ottawa, ON : Canadian Institute of Child Health 1993; 1996
CALL NUMBER: WS 125 C212N 1993, LOCATION: HEALTH SCIENCES
CALL NUMBER: WS 125 C212N 1996, LOCATION: HEALTH SCIENCES

Chetley, Andy. (1993). Protecting infant health : a health workers' guide to the international code of marketing of breastmilk substitutes.
Penang, Malaysia : Published by the International Baby Food Action Network, 1993.
CALL NUMBER: WS 120 P967 1993, LOCATION: HEALTH SCIENCES

Hale, Thomas W. (1996). Medications and mothers' milk (5th edition).
Amarillo, TX : Pharmasoft Medical Publishing, 1996.
CALL NUMBER: WS 39 H164M 1996, LOCATION: HEALTH SCIENCES

<u>Audio-visual materials</u>

Cross training. (1995). Women's health issues.
Five films: 1. Breast disease and cancer (20 min.);
2. Gynecologic cancer (25 min.);
3. Pelvic inflammatory disease and ectopic pregnancy (18 min.)
4. Menopause and hormone therapy (24 min.)
5. Uterine surgery (17 min.).
[video films (VHS) - 1 hr. 44 min.]
Baltimore, MD : Williams & Wilkins, 1995.
CALL NUMBER: WY 156.7 C951 1995, LOCATION: HEALTH SCIENCES

Disabilities and motherhood.
[video film - 25 min. : sd., col. ; 1/2 in].
Princeton, N.J. : Films for the Humanities and Sciences, 1995.
CALL NUMBER: 800 341, LOCATION: CAVE

La Leche League Canada. The Art of breastfeeding.
Three chapters: 1. Nature knows best; 2. The art that you can learn; 3. One day at a time). English translation of La Ligue La Leche. (1993?) L'Art de l'Allaitement.
[video film - 55 minutes].
CALL NUMBER: WS 125 A785 199-, LOCATION: HEALTH SCIENCES

National AIDS Clearing House. (1995). Journey home.
Three chapters about aboriginal people with HIV/AIDS:
1. A young mother; 2. A young man; 3. An older man.
Funding provided by Medical Services Branch, Health Canada
[video film - 39 minutes]
CALL NUMBER: LOCATION: HEALTH SCIENCES

Unsung lullabies : personal stories about miscarriage. (1995).
Pt. 1. Miscarriage affects everyone differently (12 min.)
Pt. 2. Coping with a miscarriage (18 min.)
Pt. 3. Moving forward (18 min.).
Vancouver, BC : No Time To Cry Publications ;
Montreal, QU : distributed by National Film Board of Canada, 1995.
[video film (VHS) (48 min.) : sd., col. ; 1/2 in.]
CALL NUMBER: WQ 225 U59 1995, LOCATION: HEALTH SCIENCES

Conference Calendar

Up to $500 is available annually to a member, whose Alliance registration fees are paid up-to-date, to help pay the cost of attending a conference which is in keeping with the Alliance objectives of care to women and babies. So that members are aware of the conferences being offered it has been suggested that we list those which may be of interest. Just because a conference is listed does not mean that it necessarily meets the Alliance objectives. (Some money is still available for 1996). If you know of any conferences, meetings, etc. which could be of interest to members please forward the information to the editor for inclusion in the Newsletter. For International Conferences the call for Abstracts is usually one year or more before the conference date. Often only mailed, not faxed, abstracts are considered. (Readers are responsible for checking the information of the conferences listed. As the information comes from a variety of sources the Editor accepts no responsibility for any misinformation).

1996

Sept. 25. "Changing Childbirth and the Midwife - 3 years on". Leicester. Topics include practice and management issues. Speakers include Mary Hamilton (coauthor of Changing Childbirth and the midwife", Jane Sandall from the University of Surrey and others.
Cost: £40, includes lunch.
Contact: Mavis Sharman, 13 Iris Avenue, Glen Parva, Leicester LE2 9JJ, UK (Telephone: 011-44-116-278-2967).

Sept. 30. "The Hammersmith Hospitals NHS Trust Symposium: Milk Banking, Past, Present, and Future", London, England.
Contact: Course Registration Service, PO Box 3219, London SW13 9XR (Telephone: 44-181-741-1311).

Sept. 30-Oct. 3. "Nursing in the New Millennium. Beyond Tomorrow: Building Nursing Skills for the Future", Winnipeg. Innovation in nursing and nursing care delivery. Keynote speakers: Tim Porter-O'Grady and Angela Barron McBride. (Rescheduled).
Contact: Communication Dept., Manitoba Association of Registered Nurses, 647 Broadway, Winnipeg, MN R3C 0X2. (Fax: 204-775-6052; e-mail: marn@marn.mb.ca)

Sept. 30-Oct. 6. **Canada's Breastfeeding Week - Breastfeeding: A Community Responsibility.**
Suggestions to: INFACT Canada/IBFAN North America, 10 Trinity Square, Toronto, ON M5G 1B1 (Fax: 416-591-9355; e-mail: infact@ftn.net)

October 3. ASPO/Lamaze certification examination
Deadline for application: August 9, 1996
Contact: ASPO/Lamaze, 1200 19th Street NW, Suite 300, Washington, DC 20036 (Telephone: 1-800-368-4404)

October 3-4. "Breastfeeding: Committee to Community Action", Winnipeg.
Contact: Shirley Phillips, Winnipeg Breastfeeding Clinic. (Telephone: 204-231-5855).

October 3-5. "Fetus and Newborn: State-of-the-Art Care", Washington. Includes: new therapies, complex patients, neonatal technologies, brain resuscitative measures, nitric oxide and liquid ventilation, neonatal apnoea, etc.
Contact: Contemporary Forums, 11900 Silvergate Drive, Dept. 202, Dublin, CA 94568. (Fax: 510-828-2121 Dept. 194; e-mail: hlth@cforums.com)

October 3-6. "Midwifery: Reaching Beyond Our Goals", Orlando, Florida. October 7 post conference workshop - hands-on herb class, or basic suturing and advanced suturing.
Contact: Midwifery Today, P.O. Box 2672, Eugene, Oregon 97402 (Fax: 541-344-1422; telephone: 1-800-743-0974; e-mail: midwifery@aol.com)

October 4. "Gentle Beginnings for Mothers and Babies", Bedford, New Hampshire. A full day workshop with Marshall Klaus. Sponsored by March of Dimes.
Cost: $110 includes materials, continental breakfast, breaks and a buffet luncheon. Registration deadline: September 9.
Contact: Barbara Harling, Maternity Unit, Monadnock Community Hospital, 452 Old Street Road, Peterborough, NH 03458 (Telephone: 603-924-7191, ext. 4170).

October 10-12. "Ambulatory OB/GYN Nursing 10th Annual Conference", Washington. For office, clinic, and advanced practice nurses.
Contact: Contemporary Forums, 11900 Silvergate Drive, Dept. 202, Dublin, CA 94568. (Fax: 510-828-2121 Dept. 202; e-mail: hlth@cforums.com)

October 11-13. "Keeping Birth Normal", New York.
Contact: Midwifery Today, P.O. Box 2672, Eugene, Oregon 97402 (Fax: 541-344-1422; telephone: 1-800-743-0974; e-mail: midwifery@aol.com)

October 13-16. "1st International Conference on Priorities in Health Care Needs, Ethics, Economy and Implementation", Stockholm, Sweden.
Contact: Priorities in Health Care, Stockholm Convention Bureau, PO Box 6911, S-102 39, Stockholm, Sweden (Fax: 46 8 34 84 41)

October 14-18. "Breastfeeding: Science and Ethics, Theory and Practice", to be held in an Asian country. To look beyond the Innocenti Declaration by evaluating efforts since 1990, to build new commitments, to mobilise, update, train and encourage sharing.
Contact: Global Forum on Breastfeeding, c/o WABA Secretariat, P.O. Box 1200, 10850 Penang, Malaysia. (Fax: 60-4-657-2655)

October 16. "Towards Developing a Flexible Health Workforce". Ottawa. Initiated by various associations including CNA with support from Health Canada. The next day there is a follow-up workshop to discuss in more details the conference recommendations.
Cost: $160 for conference; $100 to observe follow-up workshop.
Contact: Canadian Association of Occupational Therapists, Carleton Technology and Training Centre, Suite 3400, Carleton University Campus, 1125 Colonel By Drive, Ottawa, ON K1S 5R1 (Fax: 613-523-2552). Or: Beatrice Mullington, Canadian Nurses Association, 50 Driveway, Ottawa, ON K2P 1E2 (Fax: 613-237-3520; telephone: 1-800-361-8404)

October 17-18. "Rural Newfoundland - Perhaps Better Than You Thought?!" St. John's. The intent is to bring together inter-disciplinary health professionals and community representatives to discuss recruitment, retention, and rural research.
Cost: $50; students free. Lunch $15 for all.
Contact: The Working Group on Rural Medicine, Office of Rural Medicine, Faculty of Medicine, Room H2901, Health Sciences Centre, St. John's, NF A1B 3V6 (Telephone: 709-737-5152; Fax: 709-737-6032/709-737-6746).

October 17-18. "Women's Health in the 21st Century: Nursing Support for Natural Processes", Ogunquit, ME. District 1 AWHONN conference. Topics include: therapeutic touch, non-pharmacological pain relief, hypnosis in childbearing, menopause, infertility, self esteem, empowerment, breastfeeding.
Cost: AWHONN members $165/non-members $185. After October 1 add $20. Includes lunch both days.
Contact: Betty Cowing, RR 4, Box 870, Oakland, ME 04963 (Telephone: 207-465-2510)

October 17-20. "Deciding for Others: Power, Politics and Ethics", 8th Annual Canadian Bioethics Society Conference, Montreal.
Contact: Dr. Edward W. Keyserlingk, Faculty of Medicine, McGill University, 3690 Peel Street, Montreal, PQ, H3A 1W9 (Fax: 514-398-4668).

October 18-20. "Women for a Caring Society", Battery Hotel, St. John's, NF. October 21 will be lobbying provincial politicians.
Cost: $75 by October 1/$100 after October 1 (Special rates for those in need of assistance - ask PACSW)
Contact: Angela Drake, Provincial Advisory Council on the Status of Women, 131 LeMarchant Road, St. John's, NF, A1C 2H3 (Fax: 709-753-7061; Telephone: 709-753-7314).

October 19. "Safe Motherhood: What Works?" London, England.
Contact: Trudy Stevens, Centre for Midwifery Practice, Queen Charlotte's Hospital, Goldhawk Road, London W6 0XG (Fax: 44-181-740-3512)

October 21-22. "Our Heritage as Leaders", National Conference on Nursing Administration, Ottawa. Sponsored by: CAUSN, CCHSE, CHA, CNA, CPHA. Speakers include: Tim Porter O'Grady, Judith Shamian, Ginette Rodger. Designed for those with management responsibilities for nursing services, medical directors, consultants, nurses etc.
Cost: $450
Contact: Marilyn Laidlaw, Conference Coordinator, Canadian College of Health Service Executives, Suite 402, 350 Sparks Street, Ottawa, On K1R 7S8 (Telephone:1-800-363-9056; e-mail: CCHSE@hpb.hwc.ca)

October 25. "Violence in Our Children and Youth: A Professional Challenge", Halifax.
Contact: IWK-Grace Health Centre, Halifax. (Telephone: 902-420-3108)

October 26-29. "The Perinatal Hurricane: A Class IV Storm", District IV AWHONN Conference, Orlando, Florida.
Contact: Connie Warren, Conference Chair. (Telephone: 407-897-5600; ext. 2394)

October 27-29. Canadian Association for Community Care, Annual Conference and Trade Show, Halifax.
Contact: (Telephone: 613-241-7510).

October 30-November 2. "Tobacco-Free Canada". Second National Conference on Tobacco or Health, Ottawa. Policy making, access to information, research, support for community action, women, children, aboriginal etc.
Cost: $350 for full conference.
Contact: c/o Taylor & Associates, P.O. Box 46066, 2339 Ogilvie Road, Gloucester, ON K1J 9M7 (Fax: 613-745-1846).

November 3-6. "Appropriate Systems/Appropriate Decisions, Information Technology Issues in Community Health" ITCH '96 conference, Victoria, BC. Topics related to, but not limited, to application or technology.
Contact: ITCH '96, c/o Conference Management, Division of Continuing Studies, University of Victoria, PO Box 3030, MS 8451, Victoria, BC V8W 3N6 (Fax: 604-721-8774; E-mail: ITCH@HSD.UVIC.CA)

November 4-6. "Ambulatory Paediatrics", New Orleans.
Contact: Contemporary Forums, 11900 Silvergate Drive, Dept. 202, Dublin, CA 94568. (Fax: 510-828-2121 Dept. 202; e-mail: hlth@cforums.com)

November 5-18. "Seventh International Congress on Women's Health Issues", Khon Kaen, Thailand.
Contact: Earmpon Thongkrajai RN, Associate Professor, Faculty of Nursing, Khon Kaen University, Khon Kaen 40002, Thailand (Fax: 043-237606 or 43-242106).

November 6-7. "Midwifery Practice in the 1990s", London, UK. Midwives need clinical expertise and to be able to communicate both on paper and by using computers. There are a total of 10 days for covering these essential skills, and personal and professional development.
Cost: £25 per day.
Contact: Events Administration, Education and Practice Development, Royal College of Midwives, 15 Mansfield Street, London W1M 0BE, UK. (Telephone: 011-44-171-872-5179)

November 7. "Induction and Augmentation of Labour: A Closer Look at the Benefits and Risks", Toronto. Speakers include: Robert Liston, Mary Hannah, Ellen Hodnett, Greg Ryan, Chris Sternberg, Rory Windrim, Patricia McNiven, Janet Rush, Joan Tramner
Cost: $100 before October 25/ $110 after October 25. Group of 5 or more registering at same time before October 25 - $90 each.
Contact: Maternal, Infant and Reproductive Health Research Unit, 790 Bay Street, Suite 712, Toronto, ON, M5G 1N8 (Fax: 416-351-3771)

November 8. "4th Annual HIV/AIDS Conference: Women and AIDS", Windsor, ON
Contact: Debbie Andrews, HIV Care Program, 1995 Lens Avenue, Windsor, ON N8W 1L9 (Fax: 519-254-0883).

November 8-9. "Intrapartum Nursing Practice Summit", Washington, DC. Speakers include Celeste Phillips, Sue Woodson, Cyndy Kreming, Bonnie Flood Chez and others. There will be an Open Forum session.
Cost: Before October 25 $225 AWHONN members, $275 non-members/ late registration $275 and $325 US
Contact: AWHONN, Suite 600, 700 14th Street NW, Washington, DC 20005-2019. (Telephone: 1-800-673-8499; Fax: 202-737-0575).

November 9-13. "Healing our Nations: 4th Canadian Aboriginal Conference on HV/AIDS and Related Issues", Halifax. Sponsored by the Atlantic First Nations AIDS Task Force and the Union of Nova Scotia Indians.
Contact: Conference Coordinator, Atlantic First Nations AIDS Task Force, PO Box 47049, Halifax, NS B3K 2B0. (Telephone: 1-800-565-4255; Fax: 902-492-0500).

November 10-13. "3rd Canadian Conference on International Health", Ottawa. Sponsored by the Canadian Society for International Health and the Canadian University Consortium for Health in Development.
Contact: Deborah Shnay, CCIH '96. (Fax: 613-230-8401; e-mail: csih@fox.nstn.ca)

November 10-14. "9th Congress of the Federation of the Asia and Oceania Perinatal Societies", Singapore.
Contact: The 9th FAOCP Congress Secretariat, Ken-Air Destination Management Co Pte Ltd., 35 Selegie Road #09-19, Parklane Shopping Mall, Singapore 0718. (Fax: 65-336-3613).

November 14-16. "Developmental Interventions in Neonatal Care", Los Angeles. More than 30 nationally recognized speakers will discuss specific intervention skills and multi-disciplinary challenges of the high risk neonate.
Contact: Contemporary Forums, 11900 Silvergate Drive, Dept. 202, Dublin, CA 94568. (Fax: 510-828-2121 Dept. 202; e-mail: hlth@cforums.com)

November 21. "Midwifery Practice in the 1990s", London, UK. Midwives need clinical expertise and to be able to communicate both on paper and by using computers. There are a total of 10 days for covering these essential skills, and personal and professional development.
Cost: £25 per day.
Contact: Events Administration, Education and Practice Development, Royal College of Midwives, 15 Mansfield Street, London W1M 0BE, UK. (Telephone: 011-44-171-872-5179)

November 28-30. "Interdisciplinary Health Research Conference", Ottawa. Sponsored by the CNA, CNF, CNRG, CAUSN. Themes include collaboration with other disciplines, interdisciplinary work, multicentred research, fusion of research with practice.
Abstracts: September 30, 1996. No special format, 250 words or less, title, name, address, telephone and fax numbers. Send to: Conference Secretariat, c/o P.O. Box 84049, Pinecrest Post Office, Ottawa, ON K2C 3Z2 (Fax: 613-829-2883).
Cost: $401.25/ students $267.50. Preconference workshop $53.50
Contact: Conference Secretariat, c/o CAUSN, 350 Albert Street, Suite 325, Ottawa, ON K1R 1B1. (Fax: 613-563-7739; E-mail: CAUSN@ACADVM1.UOTTAWA.CA)

December 2-6. "WABA Global Forum: Children's Health, Children's Rights: Action for the 21st Century", Asia.
Contact: Susan Siew, WABA Global Forum Coordinator, WABA, PO Box 1200, 10850 Penang, Malaysia. (Fax: 60-4-657-2655).

December 5. "Midwifery Practice in the 1990s", London, UK. Midwives need clinical expertise and to be able to communicate both on paper and by using computers. There are a total of 10 days for covering these essential skills, and personal and professional development.
Cost: £25 per day.
Contact: Events Administration, Education and Practice Development, Royal College of Midwives, 15 Mansfield Street, London W1M 0BE, UK. (Telephone: 011-44-171-872-5179)

December 8-11. Women's Health Care Conference, Washington, DC
Cost: $250.
Contact: AWHONN, Suite 600, 700 14th Street NW, Washington, DC 20005-2019 (Telephone: 1-800-673-8499).

1997

? "Weaving a Global Future III", London, England. Speakers: Sheila Kitzinger, Nicky Leap, Ina May Gaskin, Penny Simkin, Michel Odent Contact: Midwifery Today, P.O. Box 2672, Eugene, Oregon 97402 (Fax: 541-344-1422; telephone: 1-800-743-0974; e-mail: midwifery@aol.com)

? Association of Radical Midwives 21st birthday celebration. Contact: Ishbel Kargar, 62 Greetby Hill, Ormskirk, L39 2DT (Subscription of the ARM which includes the Midwifery Matters journal is £30 p.a. The 1996 autumn issue of the journal is on overseas midwifery. Articles to be submitted by the beginning of July 1996. ARM items for sale include pinard stethoscopes £6 + pp)

January 9. "Midwifery Practice in the 1990s", London, UK. Midwives need clinical expertise and to be able to communicate both on paper and by using computers. This is a 10 day course covering these essential skills, and personal and professional development.
Cost: £25 per day.
Contact: Events Administration, Education and Practice Development, Royal College of Midwives, 15 Mansfield Street, London W1M 0BE, UK. (Telephone: 011-44-171-872-5179)

January 23. "Midwifery Practice in the 1990s", London, UK. Midwives need clinical expertise and to be able to communicate both on paper and by using computers. There are a total of 10 days for covering these essential skills, and personal and professional development.
Cost: £25 per day.
Contact: Events Administration, Education and Practice Development, Royal College of Midwives, 15 Mansfield Street, London W1M 0BE, UK. (Telephone: 011-44-171-872-5179)

Jan. 25-Feb. 1. "5th Neonatal Perinatal Conference at Sea", western Caribbean from Miami. Speakers: Ellen Tappero and Keiko Torgerson
Cost: From $1204 US.
Contact: Barbara Quinn. (Telephone: 1-800-656-3221)

Febrary 6. "Midwifery Practice in the 1990s", London, UK. Midwives need clinical expertise and to be able to communicate both on paper and by using computers. There are a total of 10 days for covering these essential skills, and personal and professional development.
Cost: £25 per day.
Contact: Events Administration, Education and Practice Development, Royal College of Midwives, 15 Mansfield Street, London W1M 0BE, UK. (Telephone: 011-44-171-872-5179)

February 20-22. "Taking Hold of Our Future. Linking Education, Practice, Research, and Technology", Edmonton. Western Region Canadian Association of University Schools of Nursing Conference. Contact: WRCAUSN Program Committee, Faculty of Nursing, university of Alberta, 3rd Floor Clinical Sciences Building, Edmonton, AB (Fax: 403-492-2551; e-mail: dromyn@ua-nursing.ualberta.ca)

Febrary 20. "Midwifery Practice in the 1990s", London, UK. Midwives need clinical expertise and to be able to communicate both on paper and by using computers. There are a total of 10 days for covering these essential skills, and personal and professional development.
Cost: £25 per day.
Contact: Events Administration, Education and Practice Development, Royal College of Midwives, 15 Mansfield Street, London W1M 0BE, UK. (Telephone: 011-44-171-872-5179)

February 28-March 2. "Childbirth in the 1990s", Chiang Mai, Thailand. 1st Asean International Conference. Leading specialists from USA, UK, France, Denmark, Japan, Thailand.
Contact: Birth Without Borders, P.O. Box 111, Phra Singh, Chiang Mai 50200, Thailand (Fax: 66-53-271-590)

March 5-6. "Midwifery Practice in the 1990s", London, UK. Midwives need clinical expertise and to be able to communicate both on paper and by using computers. There are a total of 10 days for covering these essential skills, and personal and professional development.
Cost: £25 per day.
Contact: Events Administration, Education and Practice Development, Royal College of Midwives, 15 Mansfield Street, London W1M 0BE, UK. (Telephone: 011-44-171-872-5179)

March 7-8. "Breast Cancer: Myths and Realities", Vancouver.
Contact: (Fax: 604-822-4835; e-mail: elaine@cehs.ubc.ca).

April 8. "Research in Midwifery", Aston University.
Contact: Sue Cammerloher, Conference Administrator, Moorside, Yatton, Bristol BS19 4Rl, England (Fax: 011-44-1934-832164)

April 4-5. "Nurses, Women and Families: How are We Making an Impact?" Joint 8th Annual COGNN & 19th Annual IWK-Grace Conference, Halifax. Themes of obstetric, women's health, neonatal nursing, infants, families, administration, education.
Abstracts: October 18, 1996, (late submissions will <u>not</u> be reviewed), on supplied abstract form.
Contact: Faith Wight Moffatt, School of Nursing, Dalhousie University, 5869 University Avenue, Halifax, NS B3H 3J5 (Fax: 902-494-3487).

April 10-11. "Clinical Care of the Child and Family", 7th Paediatric Nursing Research Symposium, Montreal. Keynote speakers are Lorraine M. Wright and Judith Ritchie.
Abstracts: November 15, 1996, by 1700 hours.
Contact: Judith Collinge, A-412, Montreal Children's Hospital, 2300 Tupper Street, Montreal, PQ, H3H 1P3 (Fax: 514-934-4355; E-mail: jcolnur@mchnurse.chis.mcgill.ca)

June 12-13. "Third International Standing Conference on the Regulation of Nursing and Midwifery", (UKCC), Vancouver.
Contact: (Telephone: 416-928-0900, ext. 302).

June 15-18. "Capitol Opportunities", AWHONN Convention, Washington, DC.
Cost: AWHONN members $275; non-members $375.
Contact: AWHONN, Suite 600, 700 14th Street NW, Washington, DC 20005-2019 (Telephone: 1-800-673-8499 ext. 1615).

June 15-20. "Sharing the Health Challenge", Vancouver. 21st ICN Quadrennial Congress. Topics include managing health resources, quality improvement, law and regulation, ethics and human rights, research, informatics, clinical, cultural, entrepreneurial, mental health, women's health, health promotion, care givers, etc.
Contact: Canadian Nurses Association, 50 Driveway, Ottawa, ON K2P 1E2 (Fax: 613-237-3520; telephone: 1-800-361-8404)

June 21. "Sharing the Health Challenge: A Research Perspective", Vancouver. Sigma Theta Tau International's 9th International Nursing Research Congress. Areas of topics include: women's health, child health, family health, nursing education.
Abstracts: October 15, 1996.
Contact: Research Services (Fax: 317-634-8188; e-mail: barbara@stti-sun-iupui.edu)

June 21-25. Society of Obstetricians and Gynaecologists of Canada, 53rd Annual Clinical Meeting, Halifax.
June 25 (over-lap day) sessions of perinatal/neonatal interest.
Abstracts: January 31, 1997.
Contact: SOGC, 774 Echo Drive, Ottawa, ON K1S 5N8 (Telephone: 1-800-561-2416; Fax: 613-730-4314)

June 22. "Globalization of Graduate Nursing Education", Vancouver. CAUSN/AACN Post-ICN Workshop planned by UBC.

June 25-? Canadian Paediatric Society Annual meeting, Halifax.
June 25 (over-lap day) sessions of perinatal/neonatal interest.
Contact: CPS, 401 Smyth Road, Ottawa, ON K1H 8L1 (Fax: 613-737-2794)

August 13-15. "Second International Conference on Community Health Nursing Research", Edinburgh.
Contact: Karen Stewart, Conference and Exhibition Unit, Royal College of Nursing, 20 Cavendish Square, London W1M 0AB, UK

September 27-30. "Stepping into the Baby Friendly Initiative", Breastfeeding Committee for Canada conference, Ontario.
Contact: Cheryl A. Levitt, Co-Chair, BCC, P.O. Box 65114, Toronto, ON, M4K 3Z2 (Fax: 905-528-5337; E-mail: clevitt@fhs.mcmaster.ca)

October ? "Clinical Nurse Specialist Conference", Halifax.
Contact: Kathy McKay CNS, Nephrology, IWK-Grace Health Centre, Halifax. (Fax: 902-428-3285; E-mail: Kmckay@iwkhosp.ns.ca)

October 5-8. "Second European Nursing Congress", Amsterdam. Contact: European Nursing Congress Foundation, Postbox 74713, 1070 BS Amsterdam, Netherlands (Fax: 31-20-673-7306).

Education

Clarke, R. A. (1995). Midwives, their employers and the UKCC: An eternally unethical triangle, Nursing Ethics, 2(3), 247-253. This article raises the question as to whether midwives can really be autonomous when working for an employer such as the National Health Service.

International Council of Nurses. (1996). Better health through nursing research. ICN, 3 Place Jean Marteau, CH-1201, Geneva, Switzerland. This document was produced for International Nurses Day 1996 and contains a copy of the ICN "Definition of Nursing Research", ICN "Resolution on Nursing Research" (1993), and "The Role of Health Research" from the 43rd World Health Assembly (1990).

Phillips, S. (1996, May/June). Midwives. A look at the past, present and future. Along the Coast [GRHS], 11(4), 1, 12. Sylvia, who is a member of the Alliance, reports on an interview which she had with an elderly retired midwife.

Turnbull et al. (1996). Randomised, controlled trial of efficacy of midwife-managed care. Lancet, 348, 213-218. This article, by 12 authors, compares midwife-managed care (648 women) with care shared by hospital, community physicians and midwives (651 women). Women who were midwife-managed had fewer inductions of labour, fewer episiotomies, more satisfaction with antenatal, intrapartum, and both hospital-based and home-based postnatal care than those who were shared-managed. No significant differences in perineal tears and complication rates between the groups. "Midwife-managed care for healthy women, integrated within existing services, is clinically effective and enhances women's satisfaction with maternity care" (p. 213).

Newfoundland and Labrador Routine Immunization Schedule for Infants and Children as from September 1, 1996. From June 1996 Provincial Communication Disease Report

Age	Vaccine	Route
2 months	DPT&P/Hib	I.M.
4 months	DPT&P/Hib	I.M.
6 months	DPT&P/Hib	I.M.
12 months	MMR	S.C.
18 months	DPT&P/Hib	I.M.
	MMR	S.C
4-6 years	DPT&P	I.M.
Grade 4	Hepatitis B	I.M. 3 doses
Grade 9	Td&P	I.M.

The Issues of Fetuses

In Canada a fetus does not have any legal rights. This has recently been reiterated regarding pregnant women who want to continue their addictions. The FAS/FAE Joint Position Statement is in the process of being translated before being released. The results of any health promotion depends on whether or not the person wants to receive the information. In Britain there are questions being raised about fetal reduction when a woman has multiple fetuses in order that one or two may live or in the case of healthy twins only a single baby is wanted; the keeping of all fetuses in return for money for a news story; the destroying of frozen embryos because the 5 year limit set by law has expired. Canadian magazines have been reporting these happenings and an example is given below.

Does a fetus have rights? Looking for moral anchors. (Articles). (1996, August 19). Maclean's, 109(34), 16-19.

Wallace, B. (1996, August 19). When one fetus lives and one dies. Maclean's, 109(34), 20-21.

Wood, C. (1996, August 19). Beyond abortion. Maclean's, 109(34), 14-15.

[Letters] Maclean's, 109(39), 6.

International Adoption

by Pamela Walters
written when a fifth year student at
Memorial University School of Nursing

International adoption, the adoption of a child from a country other than the home country of the parent(s) (Sobol & Daly, 1995), is a pertinent issue in today's society. This is an issue as what is known is not well understood, and also there is not enough known (McCloskey & Grace, 1990). In this paper the writer will discuss why international adoption is an issue concentrating mainly on international adoption from Romania. The writer will present the history of international adoption as well as take a position on the issue and give rationale for this decision based on the impact on nursing and the health care system.

History of International Adoption

In Newfoundland and Labrador the Department of Social Services is the only agency involved with the adoption of children, although in the past churches were involved when they provided homes for young women who wanted to place their child for adoption (M. McCormack, personal communication, March 15, 1996). Also in this province only public and independent adoptions are legal. If the parents wish to have a licensed or identified adoption they must go to another province, such as Ontario, where these types of adoptions can be legalized (Wine, 1995).

Currently there are two volunteer support groups in the St. John's area directed toward adoptive parents (D. Westera, personal communication, March 11,1996). The first group, the Adoptive Parents Association of Newfoundland and Labrador, has been relatively inactive in the last 2 years. The second group, which was created by two individuals in the community, is presently active.

In the last decade there has been a decrease in the number of in-country adoptions in Canada (Sobol & Daly, 1995). This decrease is due to: an increased availability of effective birth control methods; greater access to abortion; and an increase in support for single mothers (Westhues & Cohen, 1987; Wine, 1995). The Child Welfare System is also making a greater commitment to keep families intact than in the past (McKelvey & Stevens, 1994). Recently there has also been an increase in the rate of infertility (McKelvey & Stevens, 1994) and it is estimated that approximately 1 in 10 couples in Canada have difficulty conceiving a child (Krishnan, 1994). These factors are generally not present in poorly developed countries therefore the number of adoptable infants has not similarly declined. Furthermore, the international adoption process usually takes less time than a Canadian adoption and there are more children/babies available for adoption (McKelvey & Stevens, 1994). Thus, the appeal for foreign adoption is obvious.

It is difficult to determine how many international adoptions have occurred in Canada because record keeping only began at the federal government level in 1991 (Sobol & Daly, 1995). Currently, there have been a total of 55 international adoptions in

Newfoundland (D. Westera, personal communication, March 11, 1996).

Presently, there are two types of international adoption; public and private adoption. A public international adoption is an adoption facilitated by the National Adoption Desk (the "Desk") in Ottawa. The Desk which was established by the Federal Department of National Health and Welfare in 1975 acts as an international adoption consultant and coordinator. The Desk obtains and relays information on the adoption laws and policies of other countries to the provincial government to help them advise prospective parents (Wine, 1995). A second type of adoption available is private adoption. In a private adoption the prospective parents have the choice of either working with an adoption professional who has connections with the foreign country or going directly to the foreign country themselves and working with the people there.

Once a match has been made the adoption may proceed in one of two ways. Either the child may be brought into Canada and adopted, or else the adoption takes place before the child is brought to Canada (Sobol & Daly, 1995). The Department of Social Services becomes involved when the adoption is to be finalized in Canada (M. McCormack, personal communication, March 15, 1996). This involvement means that the child is followed by the Department of Social Services for 6 months. During this time a post placement assessment is completed. If everything is going smoothly, an application for an adoption order is submitted to the courts. Once the order is issued by the court the adoption is complete. A referral may or may not be sent to the Department of Community Health at this time (M. McCormack, personal communication, March 15, 1996). In private adoptions both the Department of Social Services and the Department of Community Health are often unaware that the adoption has taken place and as a result there is no post placement follow up. Community health nurses (CHNs) do not routinely work with adoptive families (D. Ryan personal communication, March 15, 1996) and the only adoptive parents contacted by a CHN are either those who are referred through the Department of Social Services or those who call to request a visit.

Current Positions on the Issue

There are various positions on the issue of international adoption. The Canadian government supports international adoption and they work with international countries to arrange adoptions. However, there are people who consider that international adoptions should not be allowed. Health concerns, racial concerns and ethical concerns are at the core of the debate on international adoption. These concerns are discussed below.

Health Issues

Between January 1990 and April 1991 there were 1013 visas issued for Romanian children to enter Canada as landed immigrants (Marcovitch, Cesaroni, Roberts & Swanson, 1995). By the time internationally adopted children are placed with adoptive parents they are at least several months old. Therefore, one must look at the impact previous experiences may have on their present life. Many children, for example, may have experienced poor maternal nutrition during the pregnancy, inadequate infant nourishment, no

pre- or post-partum medical care, several care givers, sensory deprivation or physical/emotional abuse (Wine, 1995).

Romania's new adoption law states that institutions are to be the primary source of adoptable children in Romania (Marcovitch et al., 1995). This is a concern because of the high prevalence of human immunodeficiency virus (HIV) and hepatitis B virus (HBV) among institutionalized children (Ascher, Cieslak, & Lampe, 1992; Marcovitch et al., 1995). A study conducted by Ascher et al. (1992) found that there were 478 reported cases of clinical AIDS in Romania, of whom 424 were children including many orphans under 4 years of age. Consequently, AIDS is primarily affecting the age group that serves as the greatest pool of potential adoptive children. Another concern is that all infants born of HIV positive mothers can carry their mother's antibodies for up to 18 months after which approximately 25-40% will become infected with the virus (Ascher et al., 1992).

The adoption of large numbers of HBV carrier children constitutes a potentially serious community health problem. Since CHNs are not aware of all the international adoptions they can not properly educate and treat individuals. Laboratory test results for HBV provided to adoptive families in Romania also appear to be unreliable (Marcovitch et al., 1995; Rafuse, 1995; Zwiener, Fielman, & Squires, 1992). In one study (Marcovitch et al., 1995) parents of 16 children reported that medical evaluations completed in Canada post adoption identified that their children had medical problems such as HBV, parasites, tuberculosis, anaemia, giardia and one child was HIV positive. According to medical reports from Romania these children were all healthy when they left the country. Another study (Zwiener et al., 1992) identified 4 children, who were said to be free of infection before adoption, to have chronic HBV on arrival in the U.S. Children with HBV are at risk for developing medical complications, and they also put their adoptive families at risk for the disease (Ascher et al., 1992). Even after diagnosis of chronic HBV infection, immunization of 75% of the families was delayed for 2-9 months because of lack of awareness of potential transmission of HBV to household contacts. Presently, there are no government funded education programs available for prospective and adoptive parents (D. Ryan, personal communication, March 15, 1996).

Other common health problems noted by parents of children from orphanages were skin rashes, diarrhoea, malnutrition, parasites, dehydration, ear infections, bronchitis or jaundice (Marcovitch et al., 1995). These children are also at risk for the development of cognitive, emotional or behavioral disabilities (Wine, 1995). The older the child the older the emotional problems which result from past experiences and the more resistant the problems are to change (Marcovitch et al., 1995; McKelvey & Stevens, 1994). Evidence also suggests that educational attainment is higher in children placed earlier than placed later in life. After 2 ages of age children tend to have deficiencies in vocabulary and difficulties with writing (Marcovitch et al., 1995).

Adoptive parents should receive pre-adoption counselling

about:
1. the risks of perinatal and nosocomial infection among foreign children;
2. communicable diseases specific to the country of origin;
3. potential unreliability of medical tests;
4. screening upon arrival to Canada;
5. treatment and follow up of any positive results; and
6. general guidance concerning areas such as nutrition, safety, cultural issues and potential bonding problems (Rafuse, 1995; Zwiener et al., 1992).

On the positive side, Rafuse (1995) stated that everything other than HIV is manageable when children arrive in Canada, however, children do have to be properly screened. Humphrey and Humphrey (1993) also stated that studies carried out in the immediate years following arrival and adoptive placement implied that on the whole the children quickly overcame developmental, linguistic and behavioral difficulties. Furthermore, adoptive parents stated that there are advantages to adopting the older child. Firstly, the child is old enough to participate in family activities upon arrival. Secondly, they can easily communicate and reason with the child. Thirdly, they do not have to tell the child about the adoption. Fourthly the child is old enough to communicate thoughts and feelings (Kadushin, 1970).

Transcultural Issues

Trans-racial and trans-ethnic concerns are also important in the issue of international adoption. Wine (1995) stated that studies have shown that children of trans-racial adoption lose their racial identity, they are exposed to discrimination and in extreme cases may be driven to feel like a social outcast. Both internationally adopted children and adults who look different in a predominantly white society are likely to face hostility and discrimination which can undermine their self esteem and mental health (Humphrey & Humphrey, 1993).

These concerns are acknowledged by the Canadian government. However, the child's need for a permanent home appears to have higher priority (Wine, 1995). Wine (1995) also stated that studies have shown that children adjust well, they assess their family relationships as positive and they have a positive self esteem. Parents argue that families created by trans-racial/ trans-ethnic families may be different than those raised in a single ethnic home, however, they are not necessarily weaker. By learning about and participating in the culture of the child's background, a feeling of belonging and a sense of pride can be instilled in the children (Wine, 1995). Children whose parents associated with someone of their background tend to do better than if the parents pretended their child was white (D. Westera, personal communication, March 11, 1996). These children are also given the unique opportunity to feel at home among those of a different race or ethnicity (Wine, 1995).

Ethical Issues

Ethics is also another concern in the issue of adoption. Critics maintain that international adoption is just one more way

in which the rich exploit the poor and take their children (Wine, 1995). Children suffer because their racial and ethnic backgrounds are being weakened and the less developed country suffers because its resources, it's children, are being taken away. It is more ethical to help make changes that would improve the lives of children in their own country (Humphrey & Humphrey, 1993). Most inter-country adoptions have evolved not because of humanitarian motives but mainly because of an acute shortage of white children available for adoption in developed countries. Furthermore, inter-country adoption is irrelevant to the needs of third world children and only helps divert attention away from the real needs (Humphrey & Humphrey, 1993). On the other hand different and healthy new families are being created. International adoption meets the needs of both the adoptive parents and the adopted child. Children in distress should not suffer because their country is embarrassed by its inability to care for them. "Adopting the children does not relieve the pressure for social change but rather heightens the public's awareness of the children and their country's plight" (Wine, 1995, p. 94).

Another important concern with international adoption is limiting adoption to rich people. As previously mentioned, adopting a child from an international country through the "Desk" may take years, however, it is considerably cheaper than a private international adoption. A private adoption is quicker but costs could range between $2,000-$20,000 depending on the type of professional persons involved as these people are usually interested in making a profit. One must wonder is it ethically correct to trade a child for money?

Assurance is needed that the adopted child is the legal child of the acclaimed birth mother as it has been known for lawyers and institutions to kidnap children to supply to foreign couples (Fieweger, 1991). In other cases poverty stricken parents were persuaded by economic enticements to place their children for adoption and the use of threats were not unknown (Fieweger, 1991). D. Westera (personal communication, March 11, 1996) stated that some private adoption agencies do genetic testing to ensure that the child is the birth child of the acclaimed mother and not obtained from the black market.

Impact on Nursing

If international adoption is allowed to continue it will have an impact on nursing. Presently, there are a lack of services available for prospective and adoptive parents. Adoptive parents need as much or more support from the nursing profession as biological parents (Lobar & Phillips, 1994). To be of help to adoptive parents nurses must educate themselves about adoption. Nurses can then play several roles in the adoption process. During role changes experienced by couples the nurse can assist by assessing, anticipating and fulfilling the couple's need for support and education. Nurses should also teach adoptive parenting classes through community based education programs including parenting skills education, such as physical contact and infant care and how to foster the attachment relationship during the post

adoption period (Lobar & Phillips, 1994). Nurses can also counsel parents about special issues that impact on adoptive parenting, such as when and how to tell the child about their birth and adoption (Lobar & Phillips, 1994). In Westhues and Cohen's (1994, cited in Wine, 1995) study of inter-country adoptions parents reported that they felt they had not received enough information about the child at the time of the adoption and pre-adoption counselling and post-adoption services were lacking. Many families reported that developmental workshops, multi-disciplinary assessments and recommendations on behaviour have been helpful and are needed (Marcovitch et al., 1995).

Impact on the Health Care System

International adoption has an impact on the health care system, and nurses may see this impact in the acute care setting. If people bringing children into the country are unaware that they are carriers of communicable diseases such as tuberculosis, they may spread it to other individuals. Eventually these children and their families may have to be treated in hospital.

Stephenson (1993, cited in Marcovitch et al., 1995) found that for children adopted directly from an institution, 60% had nutritional or growth problems, 20% had a physical disability and 30% had moderate to severe psychomotor retardation. These children will need services of highly skilled health care professionals once they are in Canada. Since medical reports of other countries are often unreliable medical examinations and medical treatments are also necessary once the child has entered Canada. This will have a direct impact on the health care system which is funded by the Canadian government. Furthermore, several children have entered Canada who are HIV positive and may eventually develop AIDS. This will also have a financial impact on the health care system, as the cost of treating one individual with AIDS per year is between $38,420 and $52,675 (Zowell, Fraser, Gilmore, Deutsch & Grover, 1990). Also, individuals with contagious diseases such as HBV can spread this disease to other individuals and increase their demand for medical care.

Personal Position on the Issue

Through a review of the literature the writer has identified a number of concerns surrounding the issue of international adoption. As previously mentioned, these concerns are centred around health, transcultural and ethical issues, and the lack of education and support for prospective and adoptive parents. Based on these concerns the writer feels that international adoption should not be practised under the present circumstances.

Conclusion

In this paper the writer presented a history of international adoption, and considered both the positive and negative sides of the issue of international adoption. Concerns were discussed including the lack of resources available for prospective and adoptive parents. Also identified was the impact that international adoption would have on nursing and on the health care system if it is allowed to continue under the present circumstances. A combination of incorrect laboratory results and a lack of medical

follow up may result in a potentially serious community health problem. From this it can be seen that international adoption is an issue of relevance in today's society.

If international adoption is to continue recommendations include that a system should be put in place so that all adoptees have a medical assessment immediately on arrival in Canada. All international adoptions, private and public, should be reported to the Department of Community Health in order to decrease the potential of undetected problems. Furthermore, a community health program should be developed to educate adoptive parents about child care and to provide emotional support while they deal with the various issues of adoption. In order to provide guidance to registered nurses the Canadian Nurses Association should have a policy statement on this issue of international adoption.

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TIPS FOR HEALTHY HIGH-FLIERS

1. Plan ahead to avoid last-minute panic and have at least two good nights' sleep before the flight.
2. Smoke less before and during flight.
3. Go easy with alcohol. It has twice the effect at altitude as at sea level. Drink plenty of water.
4. British Airways medical clearance help-line is 0181-562-7070. Call the same number for a portable oxygen supply, about £100.
5. Avoid restrictive clothing as gas in the body cavities expands by about 30 per cent. Wear comfortable shoes.
6. If nervous, talk to fellow passengers.
7. If feeling faint, drink coffee or cola for a quick lift.
8. A Jet Lag Visor worn during the flight emits computer-calculated light patterns to readjust wearer's body clock to arrival time. It costs £299 from the The Good Health Clinic or may be hired (0171-221 2266).
9. Remember to keep on the move every hour or so.
10. Farrol Kahn advises carrot juice to combat the reduced oxygen. Finally, make sure you have adequate travel insurance.

Daily Telegraph, No. 43890, July 30, 1996, p. 12

Folly that dooms embryos

In a personal view, **Ian Craft** condemns the August 1 deadline imposed on fertility centres

A TRAGEDY is almost upon us. Potential children are about to be unnecessarily destroyed, all because of bureaucratic folly.

At midnight tomorrow, more than 3,000 frozen IVF embryos will be condemned without a future, if fertility centres follow the letter of a very imperfect law and thaw them. They are the embryos of infertile couples who have not yet informed fertility centres of their wishes.

How has this situation come about, who is responsible, and is such destruction of potential life really necessary?

After the 1984 Warnock Report, doctors and scientists regulated themselves through the Voluntary and Interim Licensing Authorities, until the passing of the Human Fertilisation and Embryo Act (1990). The HFE Act became operational on August 1, 1991, with fertility centres being policed by the Human Fertilisation and Embryology Authority (HFEA) — an authoritarian and bureaucratic body distant from clinical fertility dilemmas and the aspirations of infertile couples.

HFEA officials say they are only trying to do their job, but leading clinicians have always protested that the HFE Act was badly drafted, and that Department of Health officials have got it wrong on more than one account. As a result, clinicians have been ham-strung by the law and infertile couples are disadvantaged.

Almost as soon as the HFE Act reached the statute book, additional parliamentary time had to be found to change one regulation which ludicrously prevented clinicians communicating directly with referring doctors.

Then we found that someone had put the time limit for embryo storage in the Act itself, rather than in the guidelines of the HFEA's Code of Practice, and prescribed a ridiculously short time.

Why was five years adopted for embryos and 10 for sperm? There is no evidence in humans of significant problems with prolonged storage, as some critics have irresponsibly suggested.

Was the suggestion made so that more embryos are available for research if embryo-freezing is denied to those remaining infertile? If so, there is a moral question that needs to be answered by our profession.

Anyway, what is so wrong in freezing embryos — with informed consent — for 20 or 30 years? What better way of helping an infertile couple cope with the grief resulting from the unexpected death of a teenage IVF son or daughter if frozen embryos were still in store. The chances of having another child would be much greater than having a fresh IVF attempt after 40.

Although we protested to the HFEA about the five-year time limit immediately it became known, it was only two years ago that it pointed out the limitations of this regulation to the Department of Health, and it was only this May — four years and nine months later — that fertility centres were informed that storage could be granted for a longer period for couples who have given their informed consent.

Moreover, the Department of Health has decreed that infertile women who have embryos resulting from donor sperm use, and those who require a host mother to carry their child, cannot have their embryos saved. Why are they being discriminated against? Such women are unlikely to go to the European Court of Human Rights for an injunction at this late stage, but if they did, surely they would win.

Yet it is the embryos of couples we cannot contact which will constitute the majority to be offered up on the altar of bureaucratic mismanagement.

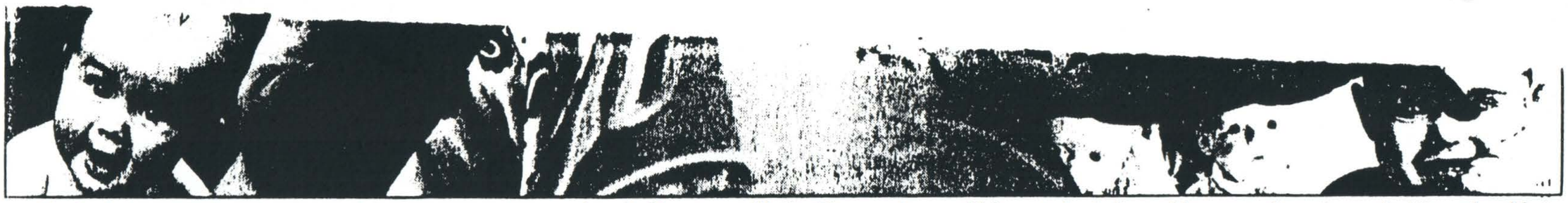
However, not all infertile couples are at fault for failing to respond to letters; in any event we had hoped that someone at the Department of Health and HFEA would have seen the error of their ways.

Why not, even at this late stage, extend the time of storage for those currently uncontactable? Of course we will have ultimately to decide what to do with embryos of couples who are truly uncontactable, but let us do so in a less emotive environment.

One even doubts that those responsible for making such ludicrous decrees will have any stirring of their conscience on Thursday morning. It is not *they* who will have to defrost the embryos.

☐ *Professor Craft is director of the London Gynaecology and Fertility Centre*

☐ *Dr James Le Fanu is away*



The body is not designed to carry eight foetuses to term, so inevitably some will die. The survivors will have to be delivered by caesarian when only 26 weeks old

Morality and catastrophe

Technology has transformed the abortion debate. Ultrasound has given greater humanity to the foetus and better ante-natal diagnosis generates new dilemmas, writes James Le Fanu

I SHARE the general public antipathy to moral argumentation. My personal views have changed a lot over the past two decades, and as I would find it impossible to convince my former 26-year-old self of my current opinions, there seems little point in trying to do so with anybody else. It is permissible, however, to elucidate the context within which moral issues arise; the better, perhaps, to allow others to make their own judgment.

The events of the past fortnight, for example, would seem to lend support to the argument that all debates about morality are futile and self-indulgent. The case of the aborted "healthy" twin initially seemed quite straightforward, although it illustrated, in a particularly dramatic way, only the implications of aborting any foetus for "social" reasons. And then along comes Miss Mandy Allwood, with her eight developing embryos, who refuses to have any of them aborted even though this might increase the chance of some at least surviving.

The obvious response is: "What's the difference?" Why should it be wrong for Professor Phillip Bennett to have aborted the healthy twin but right for Miss Allwood's obstetrician to advise that some of her healthy embryos should be selectively destroyed? It is all very confusing and only goes to show how wrong it is to have hard and fast opinions about anything.

But there is a difference that hinges on the specifics of these two cases.

Miss Allwood's multiple pregnancy is a first-order catastrophe brought about — if the newspapers are to be believed — by an extraordinary set of circumstances. Miss Allwood is a woman who has had three pregnancies in five years — the first resulted in the birth of her son, the second she terminated at 18 weeks and the third ended in a miscarriage after three months.

She was so desperate to have a further child by her new boyfriend, however, that she managed to persuade doctors to prescribe "fertility" drugs, which, after only a few days of treatment, naturally enough produced an abundance of eggs — all of which, it seems, were fertilised.

The human body is not designed to carry eight foetuses to term, so inevitably some of these embryos will die in the next few months. The remainder who do survive will have to be delivered in October by caesarian section when only 26 weeks old, the lowest age limit of viability, and so their future must also be uncertain.

It does not seem contentious in the least to attempt to correct this catastrophe by selectively terminating the lives of some of these embryos if the consequence will be that Miss Allwood can carry two of them to term, thus maximising the chance of a successful outcome. Indeed, such medical advice falls well within the criteria, as set out by the Abortion Act of 1967, that "the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman".

'A foetus can be seen moving, yawning and growing week by week'

Herein lies a substantive difference with the decision to abort the "healthy" twin. For the past 29 years since the Act was passed, doctors have justified "social" abortions on the ground that failure to terminate would "result in injury to the mental health of the mother". They recognise that this stretches the elastic criteria of the Act to breaking point. They may not be happy to do so, but as long as the memory persists of the ignominy and mortal danger that accompanied illegal abortions, they, and indeed the public, have been prepared to go along with this polite fiction on the ground that it is the lesser of two evils.

Two important developments since the Act have made this position increasingly untenable. The first is the technique of ultrasound, which, besides greatly improving the practice of obstetrics, unwittingly seems to have conferred a new status on the foetus.

Whereas previously it grew mysteriously unseen within the womb, it can now be seen moving, yawning, gasping and growing week by week. The foetus has acquired a humanity it did not previously possess, while the unambiguous evidence of the continuity of foetal development makes any decision about when to terminate a pregnancy highly arbitrary.

Second, progress in ante-natal diagnosis has generated new moral problems. It is only humane to accede to a mother's wish not to carry to term a foetus without a brain. But a different set of considerations must apply when the Abortion Act is used to legitimise abortions for conditions that are either trivial or eminently medically treatable, or, indeed, compatible with a long and useful life. The authority of the medical profession is seriously undermined when its practitioners are seen to be deploying their skills in treating illness by eliminating potential sufferers.

It is, I think, too easy to be mesmerised by the more recent issues generated by medical treatments into believing that it is all much too complicated.

However, technology is not our master but our servant and, as conscious beings, we must bend it to our will. This means restricting its uses in a way that is most compatible with the general health of society.

Dr Le Fanu is a GP

Janet Daley, page 16

No 43902

THE DAILY TELEGRAPH

14 TUESDAY, AUGUST 13, 1996

Daily Telegraph, No. 43,982, August 13, 1996, P 16

Abortion isn't always wrong

THANK you, Mandy Allwood. With your octuplet pregnancy and your deal with a tabloid newspaper, you have given us an invaluable insight into the reality of life, nature and the mentality of militant anti-abortionists. It was only last week, after all, that an unidentified single woman living in unknown circumstances was being pilloried in the most vindictive terms because she had decided that she could not cope with twins as well as her existing child.

The argument at that time from anti-abortion activists was that life was sacred: whatever the disadvantages or risks, whatever the inadequacies of the single mother's emotional and physical resources, it was categorically wrong to interfere with nature and prevent the development of one of her twin embryos.

On the crass assumption that financial need was the only problem, a considerable sum of money was raised for this hapless woman — as it happened, belatedly — in order to persuade her to have twins for whom she clearly felt herself unfit to provide a proper upbringing.

As opposed to this example of "selfishness", Mandy Allwood has pronounced herself happy to "let nature take its course". She, too, is a single mother. In fact, she appears to be one half of a rather unconventional relationship with a man who is also the partner of another woman by whom he has two children.

He has been quoted as saying that he does not plan to live with Miss Allwood after the birth of however many babies — if any — result from this pregnancy. He will, however, "stand by her" — presumably, in some sense that does not involve living with her. He has certainly played an active role thus far as her broker with the press and public relations industry.

So this week the anti-abortionists have found a heroine. Professor Jack Scarisbrick, chairman of Life, has been eloquent in his praise for Miss Allwood's decision. His comments are illuminating. He is scathing about the almost universal medical advice which she has received. "We need to get her out of the hands of the killers," he has said. In his opinion, she should be put in the care of doctors "who are pro-life, positive and caring; committed to protecting life".

The "killers" in the medical profession — which is to say, almost all of the obstetric experts consulted — have said that if some of the foetuses are not aborted, they are *all* likely to die, as indeed may the mother who, it must be remembered, already has one child.

So how exactly does Professor Scarisbrick's preferred option — which will probably result in the non-survival of all eight foetuses and the possible death of the mother — amount to a reverence for life? His desire for Miss Allwood to be placed in the hands of those who are "positive and caring" and "committed to protecting life" sits rather oddly with his other statement — that the process of "natural selection" should be allowed to take its course.

Am I alone in thinking it strange that Professor Scarisbrick — whose views on abortion are based on his Roman Catholic beliefs — should appeal to a particularly brutal interpretation of Darwinian "natural selection" for moral authority? And given the circumstances of Miss Allwood's conception, where does the word "natural" come into it?

The reason that she now finds herself carrying eight foetuses is because she was treated with hormone drugs which induced in her a completely unnatural level of fertility, and because she then disobeyed medical instructions by having intercourse while under treatment. She says that she "wants nature to take its course".

But this pregnancy is the combined product of medical intervention and her own will. Nature, left to its own devices, would not have produced this outcome. So if nature did not create this problem, it seems unlikely that, by itself, nature will provide a solution. Or, if it does, it will be a ruthless one: by the laws of Professor Scarisbrick's favoured force of "natural selection", the entire pregnancy is likely to be jettisoned as unviable.

So to the extent that these two cases have regrettably become public property, I pose the question of the fortnight: which of these women do we want to label irresponsible — or even "selfish"?

I make no definitive judgment on this personally: I know too little, particularly about the earlier case. But do not these two examples at least suggest the hypothetical possibility that there are circumstances in which deciding to have an abortion might be the *more responsible and less selfish* course?

Rearing a child is the most awesome and demanding life-long responsibility that the human condition has to offer. Might it not sometimes be a morally conscientious act for a woman to decide that she is incapable or unfit to undertake this task? (And that no amount of counselling or short-term "support" will affect the reality of her circumstances sufficiently to alter that fact.)

But what of adoption? Could not such women carry through with the pregnancy, and then offer their babies to childless couples? Some of them could, no doubt. But here the issues become muddied. One of the chief arguments used in the aborted twin case was that the surviving baby would suffer grave psychological damage as a result of the death of his twin. Would not the damage be at least as great if he were to be separated at birth from the living twin with whom he had shared the womb?

And what of even more appalling pregnancies? There was the 14-year-old rape victim who was initially forbidden to travel from Ireland to Britain for an abortion. To advocate that a raped child go through pregnancy and childbirth in order to provide a baby for adoption seems to me — as a mother of two daughters — grotesque.

And a good many people who generally oppose abortion would agree with this, because they would be overwhelmed by compassion for the 14-year-old child. But to make exceptions for an especially sympathetic candidate is to grant the principle that the pro-life lobby categorically rejects: that there is a qualitative difference between the "life" of an embryo and the life of a person. When it comes to hard cases, most people cannot bring themselves to say that a living woman (or child) should be worthy of no more concern than an embryo.

Abortion may be a battle ground between the "right to life" and "a woman's right to choose". But real cases are not about rights: they must be determined with compassion and humanity. And for those who see themselves as Christians, they should be judged with charity.

Rearing a child is the most awesome responsibility the human condition has to offer: might it not sometimes be morally conscientious for a woman to decide that she is unfit to undertake this task?

Janet Daley

Dorrell rejects curbs on fertility drug treatment

By Celia Hall, Medical Editor

STEPHEN Dorrell, the Health Secretary, yesterday ruled out any new curbs on fertility treatments following the debate over Mandy Allwood, the woman carrying eight babies.

Miss Allwood, 31, of Solihull, West Midlands, received fertility drugs but appears to have then had sexual intercourse against the advice of her doctors.

Mr Dorrell said at a briefing that fertility treatments covered a range of different treatments at a range of levels of intensity.

"The codes set for in vitro fertilisation are appropriate in very intense circumstances. They would not be appropriate to all fertility advice," he said.

He said that to extend the regulations that cover IVF to other fertility treatments would pose problems. He suggested that it would mean that a GP confronted by a couple who had failed to conceive after a couple of months, would have to engage in a "prolonged investigation of their home circumstances" before giving advice.

Mr Dorrell said on BBC Radio 4's *Today* programme earlier that there could never be any guarantee that all babies would be born into a stable family environment.

"You would have to go into licensing for babies and the horrendous apparatus of the police state if we went down that road," he said.

"We cannot go very far down that road even in the context of health advice around fertility for a simple reason — and that is that the huge majority of the advice that is given around fertility has nothing to do with these very high-tech treatments that we have been hearing about in the past few days.

"It concerns very basic advice given by GPs."

John Friend, a spokesman for the Royal College of Obstetricians and Gynaecologists said they had issued good practice guidelines on fertility treatment using drugs to stimulate ovulation.

Ovulation problems account for the infertility of more than one in five women who find it hard to conceive and many will be treated with the same drugs prescribed for Miss Allwood.

Drugs to stimulate ovulation have been given to women for more than 30 years. While some GPs will prescribe a relatively mild drug called clomiphene, the two more powerful drugs prescribed for Miss Allwood are more tightly controlled.

Normally, they are recommended only by a specialist, but often a GP will write the prescription so that the patient can get the appropriate drugs on the NHS. A course can cost up to £500.

First, Metrodin, a follicle-stimulating hormone, is taken as a pill or by injection and this encourages the ovaries to produce eggs. The second drug, Pregnyl, given by injection, encourages egg release.

A woman taking Metrodin is monitored by ultrasound scanning and blood tests on an almost daily basis. If she is found to be developing a large number of eggs, treatment normally stops and the woman is advised not to have intercourse until after her next period to avoid a multiple pregnancy.

Miss Allwood appears to have been in this situation, but it has been reported that she had intercourse against medical advice.

Had her treatment gone to plan, her consultant would have reduced the Metrodin dose so that she produced one or two eggs and then she would have been likely to have been given Pregnyl and advised when to have intercourse to maximise her chances of conception.

It was confirmed yesterday that Miss Allwood's treatment was private, but it appears that she obtained her drugs on the NHS.

Under NHS rules a private consultant is unable to write an NHS prescription but, with a willing GP, the ban can be overcome.

Globe + Mail, Sept. 9, 1996

Midwife program delivers 18 graduates

New university-taught students enter Ontario's health-care field with their skills in high demand

BY KAREN UNLAND
The Globe and Mail

TORONTO — After three 11-month terms at university and no time for a part-time job, Remi Ejiwunmi has a whopping student loan to pay off.

But Ms. Ejiwunmi, 25, isn't worried. She is about to graduate from Canada's first university-run midwifery program, and the outlook for jobs — with a starting salary of $55,000 — couldn't be better.

"I've already got clients booked for November . . . which is a nice feeling," Ms. Ejiwunmi said at the Mississauga midwifery clinic where she will work this fall, as soon as she registers with the College of Midwives of Ontario.

She and 17 other students in the joint midwifery education program at McMaster, Ryerson Polytechnic and Laurentian Universities handed in their final papers last week. Three more will finish the program this fall, and 22 other midwives are expected to be accepted to the college based on their experience, for a total of 43 new midwives in Ontario by January. They will join the 72 midwives currently registered in the province.

Midwifery wasn't even legally recognized in Ontario when Ms. Ejiwunmi and her classmates began their studies in August, 1993. Some obstetricians were leery about the practice. Many women didn't know much about it, although half of those seeking midwives in 1994 (when midwifery became regulated) were turned away, said Robin Kilpatrick, co-registrar of the College of Midwives.

Today, the province pays for midwifery care, and midwives have hospital privileges. Obstetricians and midwives have worked out a peaceful co-existence, and demand for midwives is as high as ever.

"I think it's becoming a much more understood profession," said Eileen Hutton, past president of the Association of Ontario Midwives. "If you say, 'I'm having a midwife,' people say, 'Oh, okay,' instead of 'Oh, they exist?' "

At the clinic where Ms. Ejiwunmi and another new graduate will join six registered midwives, 30 to 40 women are turned away every month, office administrator Ester Lopez said.

With some Ontario obstetricians refusing to take on new patients because the province doesn't cover malpractice insurance and claws back 10 per cent of their incomes, one might expect even higher demand for the new midwives.

But the obstetricians' battle probably won't have much effect, Ms. Kilpatrick said. "Long before the obstetricians were threatening to withdraw services, midwives were receiving more calls than they could handle."

Obstetricians are still uncomfortable with the idea of home births, which make up about half of midwife-attended births, but for the most part they see midwives as complementing their work, said Dr. Janice Willett, an obstetrician from Sault Ste. Marie.

Dr. Willett said she welcomes the arrival of the new midwives because demand is so high, especially with family doctors delivering fewer and fewer babies. "We think it's a good thing, and we think it's reasonable that people have options," she said.

Some obstetricians take issue with the different way in which they and midwives are paid. The province covers midwives' salaries, malpractice insurance and overhead costs, but obstetricians are paid per service and cover their own insurance and overhead.

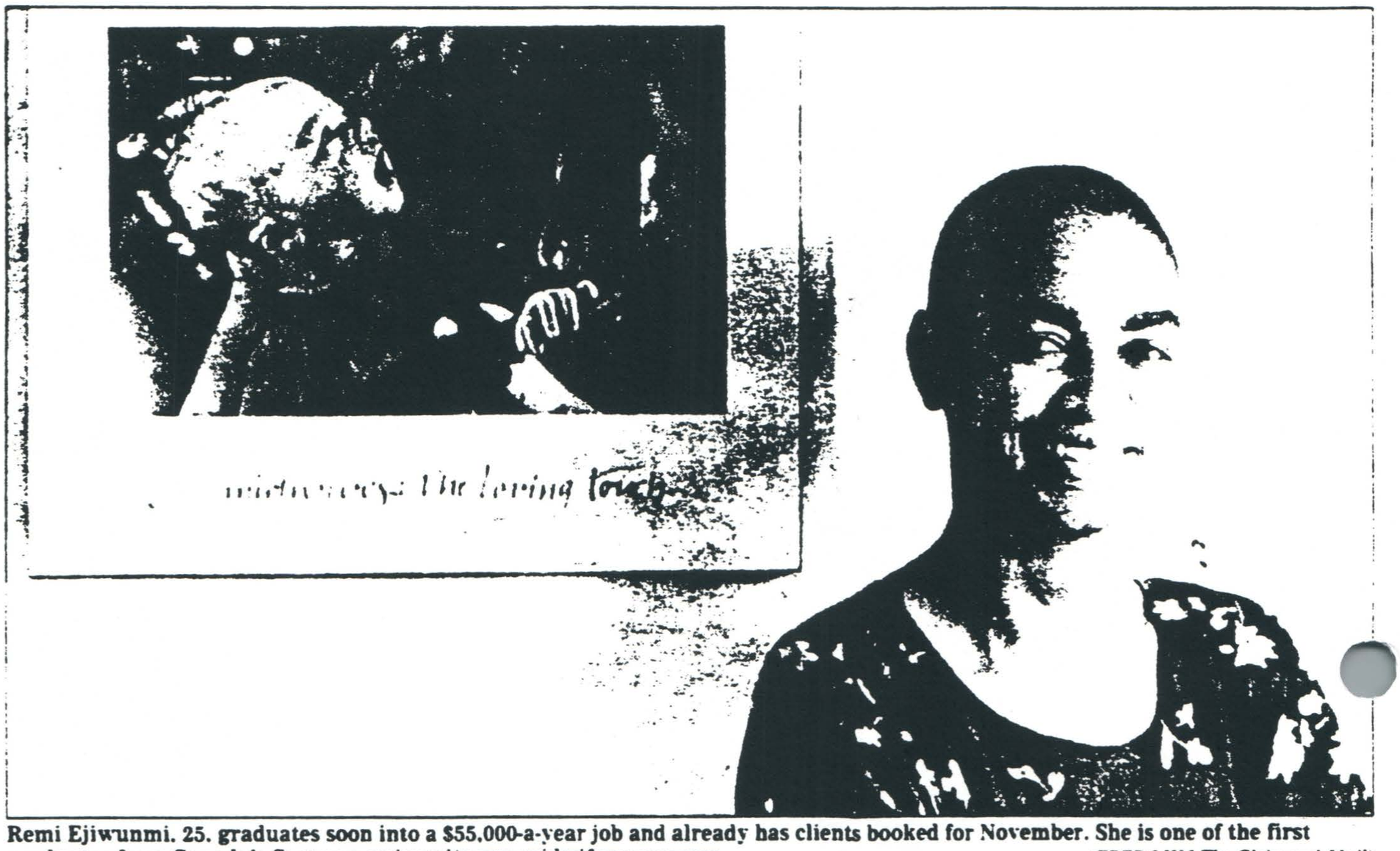
"The playing field isn't exactly level," said Dr. Marshall Redhill, a Scarborough obstetrician. "... Good luck to the midwives. I don't want parity with them. I want to be recognized as far more experienced and trained than the midwives."

Students in the midwifery program take courses over three 11-month semesters, spending about half their time doing academic work and half doing practicums at midwifery clinics, family practices, hospitals and community health centres.

Ms. Ejiwunmi, whose grandmother was a nurse-midwife in Nigeria, said her class included women who had worked as midwives before regulation, as well as women like her, who had no experience delivering babies and hadn't borne children themselves.

Proof of the program's success, she said, is that "it can take someone like me and at the end of three years make me into a good midwife."

The 18 students — four from Laurentian, six from McMaster and eight from Ryerson — celebrated on Saturday at Ryerson.



Remi Ejiwunmi, 25, graduates soon into a $55,000-a-year job and already has clients booked for November. She is one of the first graduates from Canada's first new university-run midwifery program. *(FRED LUM The Globe and Mail)*

Government secrecy

Baby milk advertising is a case in point

EDITOR,—The government's recent decision not to ban advertising of infant formula milk products emphasises Martin McKee and Tim Lang's concern that public health policies may fall prey to interests of government and industry.[1]

Throughout the formation of the two European directives and draft proposals, the British government advocated that such advertising be restricted to professional and scientific journals alone. Last year, the decision to adopt a law allowing baby milks to be advertised in hospital in effect enables expansion of the baby milk market. Such brand name advertising contravenes the World Health Organisation's international code, which clearly states that breast milk substitutes should not be promoted. This code has been supported by the British government since 1981.

During the passage of this law the Ministry of Agriculture, Fisheries, and Food received 210 letters in favour of an advertising ban and 13 against, of which 10 were from baby food companies and advertising agencies. The law came into effect before the issue was debated fully in parliament. In the eventual debate, in April 1995, the main arguments in favour of the government's position came from industry. For example, David Faber, MP for Westbury, speaking on behalf of Cow and Gate, stated, "I should have thought that is exactly what we are here for in the House of Commons—to represent business in our own constituencies and to speak up for them and their interests."

Failing to ban advertising for infant milk products rests uneasily with the government's expert working party on infant feeding, which states that breastfeeding provides the best infant nutrition.[2] The working party recommended government health departments to encourage all healthy mothers to breastfeed their babies. Guidance from the Department of Health[3] and the British Paediatric Association's standing committee on nutrition identifies the many benefits for mother and child associated with breastfeeding. A randomised trial in the United States showed that removing advertisements for formula milk improved breastfeeding rates more than did intensive efforts to train staff in breastfeeding support.[4]

The Health of the Nation white paper encourages breastfeeding of infants. It has been recommended that departments of public health should set and monitor targets for breastfeeding incidence, prevalence, and duration.[5] Allowing companies to promote formula milk products in the health care system inevitably undermines breastfeeding rates and associated infant health. McKee and Lang are right to be unsure "that the government acts in the interest of the public rather than those of the corporate backers of the party in power."

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LETTER TO EDITOR

NEWS ITEM

BRIT. MEDICAL JOURNAL.

June 8 1996

Submitted by:
Susan Felsbery.

No cause for alarm over baby milk, says EU

The scare over phthalates (chemicals that have oestrogenic activity) discovered in nine unnamed brands of baby milk in Britain now seems resolved after Britain's EU partners studied the results of the Ministry of Agriculture's tests and decided there was no cause for alarm.

Although the exact concentrations of phthalates found have not been disclosed, they did not breach the European daily limit of 25 mg per kilogram. Of 15 brands tested by the ministry, however, all contained some phthalates and nine showed concentrations similar to those that have been found to reduce testicular size and fertility in laboratory rats.

Tim Boswell, the junior agriculture minister, said that the European limit itself contained a 100-fold safety margin. He refused to name the brands tested, saying: "If there was a risk, we would name them. This is not a risk situation. We are dealing with it." Phthalates have been linked to cancer in mice, but few scientists believe they pose such a risk to humans.

The government's deputy chief medical officer, Dr Jeremy Metters, said that the Department of Health had seen the research and concluded there was no cause for alarm. "Mothers should continue to use the infant formula that they have been feeding their babies."


RUPERT CONANT/IMPACT

Breast is better

This position was supported by Dr Richard Sharpe of the Medical Research Council's reproductive biology unit, which carried out the tests into phthalates' effects on rats. "Infants are not at any risk from formula baby-milk powder because of the presence of low levels of phthalates which may have weak oestrogen activity," he said.

Dr John Chisholm, deputy chairman of the BMA's general practitioners' committee, said that parents and doctors wanted the results of the tests, not bland government assurances. "Mothers will find this frightening. They have a right to know the facts, so that they can choose milk which is safe."

The manufacturers' representative, the Infant and Dietetic Foods Association, is to work with the government to track down the source of the oestrogen mimicking chemical, used in the packaging industry to give flexibility to plastics. Possible culprits include the packaging in which raw produce arrives at the plant and the tubing used when milking cows.

With a world industrial output of about five million tonnes a year, however, phthalates could be ingested by cows if contaminated rain fell on their pasture. Other chemicals which interfere with sex hormones, such as dioxins, polychlorinated biphenyls (PCBs), and organochlorine pesticides, have been found throughout the food chain. Such pollutants have been implicated in reductions in sperm quality in Europe over the past 50 years, and there is also concern that they could play a part in the rising incidence of testicular cancer.—OWEN DYER, *freelance journalist, London*

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THE ALLIANCE OF MIDWIVES, MATERNITY AND NEONATAL NURSES OF NEWFOUNDLAND AND LABRADOR

APPLICATION FOR MEMBERSHIP
1996

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